Biomedical nemesis? Critical deliberations with regard health and social care integration for social work with older people

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Abstract

This paper questions ongoing moves towards integration into health care for social work with older people in the UK. Whilst potentially constructing clearer pathways to support integration risks reducing welfare provisions for a traditional low priority user group, while further extending privatisation. Integration models also understate the ideological impact of biomedical perspectives within health and social care domains, conflate roles and undermine the potential positive role of 'holistic' multi-agency care. Constructive social work for older people is likely to further dilute within aggressive integrated models of welfare: which will be detrimental for meeting many of the complex needs of ageing populations.

Keywords: integration; biomedical; de-professionalisation; power; older people

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Introduction

Over the past decade or more social work with older people in the UK has increasingly become assimilated within health care as part of public sector policy drivers that promote health and social care integration1 (Hudson, 2002; Lymbery, 2006; Lilo, 2016). Such integration has received popular support, and as Gray and Birrell (2013: 101) add, in principle at least, it appears to be 'popular and widely supported by practitioners, professionals, users and administrators'. Some of the key rationales for promoting the integration of health and social care provision include: that patient and service user needs have become much more complex and diverse, and typically span support from more than one service or profession; institutional boundaries further promote fragmentation and generate unnecessary professional disputes and conflict; and financial savings might be achieved with more effective, efficient and 'holistic' services that reduce convoluted interventions or the duplication of core roles such as assessments.

Subsequently (among other examples) discrete and semi-autonomous adult social service departments have dissolved in England and many have made way to integrated teams populated by health care professionals and social work staff . Many Departments that teach Social Work within Universities have moved from their traditional base within the Social Sciences to Departments of Nursing and Midwifery within wider Faculties of Health and Social Care. New health care and science orientated branches of social work have appeared or re-emerged, such as 'clinical', 'forensic', 'gerontological' and 'palliative care' social work. For older adults, ever more 'social care' concerns are 'risk-averse', crisis-centred and focused towards treating serious illness or pathological conditions such as dementia, strokes or falls. This includes as part of meeting higher-level rehabilitative, intermediate, nursing and end of life care.

Yet within such narrowly focused, precarious and risk-averse remits much social work fulfils largely low-skill auxiliary and administrative roles, while many adult social work professional tasks disappear or are fulfilled by health care professionals, psychologists or unqualified staff within local authority settings as elsewhere. The Health and Social Care Information Centre (2015: 1) notes how in England there was 'an overall decrease of 10,600 council adult social services jobs between 2013 and 2014', which represented 'an eight per cent decrease from 140,700 jobs in 2013'. Moreover, for around 'two-thirds of councils (101 out of 152) the number of adult social services jobs [continued to] reduce between 2013 and 2014'. Indeed some fields of social care such as mental health have highlighted the rapid retrenchment of social care provision (see, for example, Lilo, 2016: 38). Such political processes reflect the influence of austerity, labour market rationalisation (Baines and van den Broek, 2016) and biomedicalization within social work with older people (Means, 2007; Maddock, 2015; Lilo, 2016), yet such reforms have impacted elsewhere. For example, Furedi (2008: 46) highlights the powerful influence that health care and medicine may now hold over some children and families: 'Increasingly, troublesome behaviour among children is redefined as a mental health issue [whilst] shyness has been turned into the pathology of social phobia. Shy children are offered Luvox, a brain-altering drug, in order to protect them from distress'. In contrast, reference to the impact of social class, poor housing, inequality, poverty or structural disadvantage are notable by their absence.

This paper seeks to question and critique such changes and deeply political processes. In particular it aims to illustrate the risks posed to older people of utilising a wider integrative care narrative to elevate the influence and power of health care and medicine over social work and social care. The paper questions the rationale and validity of placing social work so firmly within fields of health, medicine and integrative care. Far from improving practices, knowledge and services, it is proposed that enforced integration undermines services for older people, and

may further conflate provisions and roles within already fragmented sectors of health and social care. Such ideological initiatives it is claimed are more about limiting cost and support, as well as extending privatisation and obscuring needs away from wider causal foundations, such as those relating to explicit structural factors including poverty and inequality. The paper concentrates upon England as a case study, yet many of the core trends and themes are echoed and hold relevance elsewhere. The article therefore draws some reference from studies in other countries.

The paper is in five parts. First, a brief overview of core policy frameworks since the 1970s is offered. The often unsuccessful attempts at integration alongside the gradual reduction of social work influence in favour of health care objectives are highlighted. Second, some of the key problems of integration are detailed, including cultural differences relating to role and status. Third, the risks of relying upon biomedical and health care perspectives of ageing are emphasised, including that constructive social work tends to diminish in favour of a series of low skill reductive practices. Fourth, the neglecting of social care related needs within a health and social care remit is discussed, alongside the hazards of conflating roles and the limited power carried by social workers in health care fields. Finally, as part of the conclusion, it is proposed that an expansion of social workers for older people- alongside moderate levels of collaboration with health care - are likely to achieve better and more efficacious outcomes for older people.

Policy background

An extraordinary number of policy led attempts have emerged to promote greater collaboration between health and social care sectors. Brown et al (2003: 85), for example, note that the difficult relationship between health and social services 'has been exercising the minds of politicians and planners for decades'. Glendinning and Means (2004: 438) add that

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such tensions have their origins in 'the structure of the post-war [British] welfare state', including the organisational and funding divisions generated between the (free at the point of service) National Health Service (NHS) and locally-elected authorities (and means-tested) support of social work and care provision. Such distinctions have generated considerable differences regards governance, policy, organisational arrangements and professional practices for older people. As Glendinning and Means (2004: 453) stress, there are, however, crucial points of commonality, which can nevertheless provoke further tensions, especially with regard a lack of adequate funding and resources:

> Our historical analysis has shown how health and social care services for older people have traditionally been 'Cinderella services' which have been woefully underfunded and that this in turn has generated decades of conflict and tension between NHS and local authority social services.

The formation of distinct social service departments (SSDs) in England and Wales during the early 1970s created a substantial degree of independence for social work from its previous association with public health, and ensured for three decades that the newly expanding welfare profession bypassed ancillary control by the medical profession within the NHS (Webb and Wistow, 1986). Reorganisation of the NHS in 1974, however, also removed district nurses and health visitors from community 'patches' where the generic social worker now reined, whilst SSDs quickly prioritised resource intensive 'child protection' work (Parsloe, 1981). Subsequently, services for older people and professional involvement from both sectors tended to be extremely limited. As Biggs (1999: 149) reflects, such policy and subsequent practices often carry significant implications for many older people, since they regularly 'come to define, in the popular mind, the shape and circumference of ageing'.

A series of largely unsuccessful 'joint planning' initiatives developed throughout the 1970s and 1980s in a bid to promote collaboration within health and social care sectors. This was viewed as imperative to accommodate the closure of long-stay hospitals, yet in practice these initiatives tended to be centrally directed and prioritised established structures and services whilst often ignoring user outcomes or needs. Hunter et al (1988), for example, stress the lack of corporeal inter-professional projects which emerged in local communities at the time, whilst the Audit Commission (1986) and Wistow (1990) detailed the multi-layered obstacles (cultural, structural, financial and professional) which hindered coherent joint planning or working (Lewis and Glennerster, 1996).

Despite previous failed attempts to promote partnership working, the Community Care initiatives disseminated throughout the 1990s - and especially the NHS and Community Care Act 1990 – appeared to invigorate a new policy-led thrust to promote collaboration in care. Rhetorical calls for 'seamless care' were commonplace, and ever more services were provided outside of direct state control, all of which provoked a need for increased regulation of different sources of provision: especially the rapidly expanding private sectors (Hadley and Clough, 1996). While some evidence of effective joint planning emerged the new core role of 'care manager' remained with qualified social workers. Social service departments became more specialised yet regular links with health care sectors were rare. Indeed Lewis and Glennerster (1996: 167-168) draw from their empirical research within five local authorities in England to reason that discord between professionals 'may have been sharpened by the introduction of the [service] purchaser-provider splits'. At street-level partnership working also remained a 'many-layered activity' with 'limits as to what formal agreements and procedures can achieve'. Rapid and extensive marketization also occurred, with resources quickly becoming squeezed and tightly controlled by central government, which generated further conflict between local authorities and institutions within the NHS.

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From 1997 the New Labour government instigated much more intense attempts to promote the integration of health and social care services. For example, the demise of social service departments in England three decades after their formation, and promotion of integrated teams (comprising social workers, nurses, occupational therapists, and so on), represented a much more significant change to past reorganisations. This was enhanced by additional reforms in relation to encouraging pooled budgets, joint commissioning, collaborative leadership and joint management, as well as allowing multiple health and social care professionals to assess needs (Gray and Birrell, 2013). Nonetheless, Means et al (2003: 120) argue that other policy initiatives such as the formation of Health Improvement Programmes (HiMPs) were openly envisaged as being health-led. Indeed the term 'service user' quickly disappeared in favour of patients within policy mandates, and, alongside a focus now placed upon health care orientated services, many social work staff were replaced with new roles such as those of 'community matrons' (Means, 2007: 53). Bradley and Manthorpe (2000) again highlight the minor role envisaged for social work in New Labour's plans for health and social care integration, whilst Poxton (1999) maintains that keeping cost down has always remained the key driver for integrating services. Gray and Birrell (2013: 105-110) add that an additional recurring problem has remained extensive funding difficulties between local authorities and health care trusts. This has included the alignment of very different financial frameworks when attempting to pool budgets, as well as dissimilar tax regimes, charging patterns, planning and budgetary timetables.

Glynos et al (2015: 65) highlight the 'ideological contexts and power dynamics' embroiled within the passage of the Health and Social Care Act 2012 in England, including its tendency to utilise integration as a powerful hegemonic tool to promote further competition and privatisation within the NHS, whilst pushing aside alternative options. In this instance

integrated care acts 'as a political logic to normalise provider-blind provision, obscuring wider contextual features linked to the landscape of power relations, hegemonic struggle, and ideological investments' (ibid: 63-64). Powell and Steel (2012: 3) add that through policies such as personalisation, participation, and integration, older people are increasingly judged by health and social care 'experts' according to their capacities to engage with markets, and, ideally, be autonomous and self-governing 'citizen-consumers':

> Those individuals who are willing and able to commit to the market and to self-manage experience a particular combination of options and opportunities while those who, for whatever reason, fail to meet this commitment experience a different and more limited set of options that are often oppressive and impersonal.

The Care Act 2014 and the *Five Year Forward View* (DOH, 2014) have again stipulated a duty on behalf of local authorities to promote more formalised integrated care, this includes social services progressively being integrated with provisions within the NHS and associated sectors such as housing.

Problems of integration

Hudson (2002) and Lymbery (2006) draw from the sociology of the professions to detail the obstacles typically preventing effective partnership working and integration in health and social care. These include that professionals tend to quickly become socialised into their distinct working cultures to form professional identities and group bonds which can prove restrictive and difficult to overcome. Status and power differences held between different professionals again remain a problem, especially the significant influence held by medics. Within health care and medicine anxiety or suspicion regarding the seemingly unclear and non-clinical activities of the social worker may prevail (Bell, 1961; Brewer and Lait, 1980;

Bywaters, 1986), alongside prejudicial assumptions of an unsound knowledge base, uncertain

methods of practice and ostensibly hazy outcomes which – in contrast to many fields of

medicine - remain difficult to clearly identify and measure (see Brewer and Lait, 1980). In

drawing upon the role of hospital social workers and the American model of welfare, Davies

(2004) adds the lack of revenue and profit generated by social workers in comparison to their

health colleagues, alongside a struggle to provide clear evidence of cost savings and

efficiencies for patients. Hudson (2002) notes that preconceptions - however unfair or

inaccurate - inevitably impact upon professional reputations, identities and performance.

Negative assumptions may also promote rivalry, resentment and embedded conflict between

different professionals in the same field of practice.

Principle differences regarding accountability and relative 'street level' discretion may again

cause further problems and undermine effective team work. This includes that social workers

often remain more accountable to bureaucratic, policy enacted and legally sanctioned

frameworks that may hinder the development of collegiate bonds. Lymbery (2005: 82-85)

highlights how effective collaboration between health and social care professions is largely

dependent upon a 'structure predicated on a parity of respect and esteem between them',

something which has remained 'more of an aspiration than a reality'. In addition, social work

remains vulnerable of being usurped by professional health care agendas and practices. There

are, nevertheless, health care professionals who fulfil roles more compatible with social work

for older people, most notably community-based nurses or occupational therapists. Despite

difficulties Crook et al (1992) argue that greater collaboration between professionals remains

inevitable as 'postmodern' societies and economies alter, and demand increasingly

specialised expertise drawn from evermore narrow fields of practice. Consequentially

practitioners specialising in ageing may have more in common with experts across

professional terrains than colleagues in the same profession who specialise in a different area such as child care. Collaboration in fields of practice such as ageing may also be strengthened when facing similar problems which affect each discipline, for example withdrawal of welfare provisions during times of economic recession, which may lead to a collective sense of solidarity or resistance emerging.

Identity management can nevertheless remain paramount to professional employees who support belief systems which concur with personal values. For example, social models, holistic care or human rights in social work. Estes and Binney (1989) maintain that within medicine and many healthcare traditions ageing is not uncommonly constructed as a medical problem typified by deterioration and dependence. Conversely the impact of factors such as biographical experiences, inequality, poverty or poor housing may be neglected or dismissed. Seemingly such traditions and discursive norms may prove difficult for some social workers (or person-centred health care employees) to work around or accept. Indeed health related pathologies may be identified, categorised and treated with an almost military like zeal, whilst other concerns become marginalised. Scragg (2006) has critically interpreted empirical findings gathered as part of an evaluation of integrated team management within a health and social care trust in England. He stresses power disparities between health professionals and social care staff and expresses concern that older people's needs were often restricted to medical interpretations alone.

Maddock's (2015: 253) exploration of the workings of a mental-health multidisciplinary team in Ireland discovered that different professionals tended to support different models of intervention. Whilst social workers and occupational therapists claimed to regularly draw influence from either social or psycho-social models of intervention, both the psychiatrist and

community psychiatric nurses relied heavily upon the medical model. Crucially, however, the psychiatrist's influence remained paramount to treatment regimes, a point reiterated by staff and the consultant psychiatrist, who stated that: 'I don't think that everybody's view carries equal weight, multidisciplinary working is very consultant centred, so I have the final say on treatment, and on who I feel requires the teams attention'. Importantly, as Maddock (2015) notes, this autocratic welfare model goes against the current Irish governments and European Union's policy directives (Department of Health and Children, 2006; Mental Health Commission 2010); in particular the call for greater levels of 'holistic' support as part of integrated multidisciplinary and community-based mental health care.

Despite rhetorical arguments in favour of integrated care, empirical evidence to support claims of more efficacious and efficient care remains in relative short supply. Indeed many studies have been less than positive. For example, Bardsley et al (2013: 4-9) note the ongoing rise in emergency admissions to hospitals for older patients, many of which could be avoided with greater preventative care, including social care support provided in community settings. Subsequently the authors critically evaluated a series of integrated service innovations in 30 different sites across England. One evaluation explored 4 out of 29 Partnership for Older People Projects (POPPs) which were funded by the Department of Health, and aimed to promote earlier and targeted integrated interventions for service users within homes and wider communities. Yet, as part of the findings, the authors stressed their difficulties finding evidence of success with regard the interventions:

> When compared to matched control patients, we did not find evidence of a reduction in emergency hospital admissions associated with any of the four POPP interventions studied. In some instances, emergency admissions in the intervention group were higher than in the control group. Only one intervention reduced the number of bed days used by patients.

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In another example, 16 pilots of integrated care interventions – such as case management for at risk older people in Norfolk, and structured care for people with dementia in Bournemouth and Poole - were evaluated for their effectiveness. These interventions illustrated some improvements regards the use of care plans and new roles developed for staff, yet other outcomes revealed a general deterioration in standards:

> Surveys of patients and service users indicated that they found it more difficult to see the doctor and nurse of their choice, and they reported being listened to less frequently and being less involved in decisions about their care. A central aim of many pilots was to reduce hospital utilisation, but over a six month period of the pilots we found no evidence of a general reduction in emergency admissions.

Alongside the speed at which many such reforms were introduced, and an increasing fragmentation of provision, a probable reason for such disappointing findings remains that dynamics such as the impact of reductions in the total number of professionals involved in care - alongside a decline in the proportion of professional social care services across sites and rising demand – were perhaps likely to undermine any possible benefits associated with integrating services.

The limits of a health and biomedical influence in understanding ageing

A key potential problem which hinders integrated care remains the powerful ideological influence which medicine holds over other disciplines and society more generally. Estes et al (2003: 82), for example, stress that that the 'biomedicalisation of ageing' struggles to accommodate other perspectives which include alternative paradigms and practices. Instead it tends to 'seal itself off from other explorations' while encouraging a formal distance between older adult users and professionals. In discussing the iatrogenic side-effects of medical interventions Illich (2010: 9) articulated the 'transformation of the doctor from an artisan

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exercising a skill on personally known individuals into a technician applying scientific rules to classes of patients'. From within this paradigm shift malpractice has seemingly 'acquired an anonymous, almost respectable status', and within:

> A complex technological hospital, negligence becomes "random human error" or "system breakdown," callousness becomes "scientific detachment," and incompetence becomes "a lack of specialized equipment." The depersonalization of diagnosis and therapy has changed malpractice from an ethical into a technical problem.

Vincent (1999: 68) has earlier noted that within medicine and health care older people - especially the oldest old - become vulnerable to being reduced to 'abnormals' who are 'studied scientifically in order to treat the 'problems' of their conduct'. Gerontology within medicine also stands as an 'intellectual strategy' which can legitimise passivity, control and neglect. In a similar vein Hughes (1995: 37) stresses the priorities given to younger groups alongside the neglect of many older people's needs as part of exclusionary health care service provisions. This includes that older people 'may not have always had the most efficacious investigation and treatment' since the 'attitudes of some medical practitioners to illness in old age has been that of 'grin and bear it''. Tanner and Harris (2008: 11), however, note that older people's needs within social work - and welfare more generally - are often assumed to be homogenous and predictable. This contrasts starkly with the increasingly diverse experiences of ageing for ever more heterogeneous groups within society, alongside greater expectations from many elders within a consumer-led society.

Whilst medical and narrowly focused health care attitudes and knowledge-centred perspectives are open to resistance – not least by users themselves or practitioners working in a multi-agency context – they still impinge upon the ways by which older people identify

themselves, and influence the beliefs and practices held by professionals within integrated teams. For example in drawing from political economy and critical gerontology Estes and Binney (1989: 108) maintain that biomedical perspectives disseminate a powerful hegemonic influence that travels beyond diagnosis, tests and treatments: to touch research, policy, practices and taken for granted assumptions regards ageing as it is 'defined and evaluated in terms of a biomedical structure of thought'. Whilst social work at least draws from different perspectives – such as humanist, critical or biopsychosocial theory if assessing older people's needs (see Richards et al, 2013) – such approaches are unlikely to maintain the legitimacy or potency of biomedical orientated paradigms. Indeed Gilbert and Powell (2010: 17) highlight the emergence of a variety of social models of ageing since the 1980s, which have seemingly challenged the medical model and disengagement theory and their emphasis upon older people's illness, incapacities, natural decline and retreat from society. Yet they also specify how market-led, organisational and professional 'relations of power have seen such commitments detached from their original radical and humanitarian moorings to feature now as components of oppressive discourses they might once have challenged'.

Bywaters (1986: 663-665) has detailed the significant risks posed by promoting collaboration between health care and social work in fields of practice. This is viewed as inevitably leading to the domination and control of social work activities by medicine. In describing studies of the work of almoners in hospitals such as those of Bell (1961) and Stacey (1983) Bywaters details their 'struggle for survival in what were experienced as hostile environments'. In particular failed accounts of co-operation persisted alongside a 'continuing refrain of inappropriate or narrowly focussed referrals'. Explicit assumptions from medics that almoners were able to only offer limited practical support, alongside hostility from medics and nurses towards any attempts made by almoners to view patients' needs in their non-medical and social context, stood alongside intense pressures to 'clear the beds' as quickly as

possible. In addition a fear of expulsion from the hospital persisted if almoners dared to question a medic or ward sister, indeed few ever did. Bywaters adds the failure of the medical profession and many health workers to recognise the impact of environment, housing, poverty, class and so forth, upon patients and service users, and concludes that collaboration is likely to lead to the proliferation of extremely narrowly focused and low-skill social work practices. Indeed a number of empirical studies exploring social work identities have illustrated that many practitioners are deeply uncomfortable about working within a health care domain (see, for example, Blinkhorn, 2004). Yet with social work - now focused ever more upon risk-averse and care managed casework of the oldest old - reliance upon medical technologies, knowledge and professional interventions continues to increase. This generates further disparities in power and influence between higher skilled and qualified employees, and unskilled staff alongside users or community based patients and their carers.

Among other ongoing reforms within industrial health care, Rose (2007) has analysed the increasing manipulation of the human body, such as through the use of biomedical technologies and drugs to influence moods, extend life and reduce ageing. While such techniques may carry positive or empowering effects for individuals - who may feel no longer entirely constrained by their biology – a number of ethical implications persist. These include that new forms of power are given to sometimes unaccountable 'experts', increasing inequalities are generated with regard access to such technologies, and added pressures are placed on the environment through the extension of the life course and increases in consumerism. In relation, Estes et al (2003: 86) add that a biomedical discourse relies upon a close bond being held with big business and new technologies. Such commercial pressures encourage the commodification of ageing, a process reinvigorated by the eradication of diseases of earlier life, meaning that older people subsequently offer a new expanding market for profit and the use of new technologies. Along with professional interests the privileging

of pricey high tech solutions and treatments sits alongside the 'transformation of remedies' into 'saleable commodities'. Nevertheless Webb (2006) and Gilbert and Powell (2007: 11) note how Information and Communications Technologies (ICTs) increasingly 'order the practice of a range of professionals including social workers'; which subsequently 'engulf all in architectural labyrinths of information' while promoting 'a form of panopticon establishing a level of surveillance of both worker and service user' that shifts 'focus away from support for clients and toward surveillance and monitoring'. In tandem with the ongoing development of a 'social work business' (Harris, 2003), such complex discursive domains of technology, knowledge and power include not merely the impact of an over reliance upon ICT's, but also ever more prescriptive 'technologies of care'. These include probing and impersonal assessments of needs, care plans and personal budgets, which ideologically frame and substantially restrict meaningful engagements with, and support for, ever more 'empowered', yet objectified, users and carers.

Neglecting social needs, conflating roles and limited power

The neglect of social needs within welfare remains a longer term trend which gathered momentum with the introduction of care management and quasi-market systems of care for adult social workers to work within in Britain throughout the 1990s. This led to limited provision, intense gatekeeping and charging for services, alongside a narrow focus placed upon meeting higher level needs whilst seeking to contain risk (Postle, 2001; Kemshall, 2002; Dustin, 2007). Such outcomes added to the traditional stigma carried by social workers and made many practitioners uneasy with their role as gatekeepers guarding minimal and ever receding social care support (Lymbery, 2006). Social needs - such as those relating to common difficulties relating to ageing populations such as loneliness, poverty, poor housing,

and so on – were quickly marginalised as priority in favour of risk-aversion at a minimal cost (Kemshall, 2002; Webb, 2006).

The more recent emphasis upon focusing welfare provision from within integrated care and teams has squeezed out further the loss of substantive social support initiated through the promotion of care management and personalisation. Means (2007: 56), for example, stresses the growth of influence of health care and subsequent marginalisation of social care needs for older people within British social policy. Seemingly medicine and health care have 'a very poor record of looking beyond acute ill-health' regards ageing populations, despite many older people wanting a 'social care response to increasingly focus on how to support them to remain included in their own communities'. Welfare services increasingly need to justify themselves as being cost effective and efficient through tangible and quantifiable outcomes, something which social work within multiagency discursive arenas - that draw additional influence from health economics, bio-medical and evidence-based hegemonies – find difficult to achieve. Bywaters (1986) highlights the potential importance of social workers advocating the human rights of users as well as privileging recognition of the substantial impact of environmental and social factors upon health and life chances. In tandem practitioners potential capacities to restrain from the professional as 'expert' while providing pedagogical support and advocacy were also viewed as distinctly positive traits that might at least in part counter biomedical reductionist techniques and interventions.

Another important limitation to integration and closer collaboration between health and social care remains that the core tasks and roles fulfilled by social workers - as well as their related training and education - remain very different to those received by health care professionals. Discursive, ideological and ethical tensions and identity clashes appear inevitable when links regards role and core knowledge ultimately remain tenuous in disparate fields of praxis. Indeed aligning professionals with a different ethos, rationale and roles may well be counter-

productive, and instead conflate sound understanding alongside purposeful or sustained interventions. Fitzpatrick (1999), for example, has questioned attempts to revise and adapt the role of General Practitioners in England to include core tasks traditionally accomplished by social workers. This includes providing pastoral and pedagogical support for patients, especially guidance on lifestyles, taking regular exercise, following a careful diet and improving parenting skills. Fitzpatrick argues that GPs lack the relevant training to fulfil such 'social work' activities, and this may alter the nature of their relationship with patients, which may lead to confusion and distrust. Some GPs now engage in what is coined 'social prescribing' (Friedli and Watson, 2004), in which they commission services in the local community, predominately from the independent or third sectors with a view to promoting exercise, art therapy and a wide range of other 'non-medical activities' which may previously have been led by social work. Again the risks of placing non-medical responsibilities onto medics with limited training, knowledge or time to consider social needs can prevail.

The low priority given to older people and social needs is again reiterated within present health and social care discourses around adult abuse. For example, Galpin (2010: 249-250) pinpoints this newer ideological thrust as being built around a 'neo-liberal focus on autonomy, individual choice and nongovernment intervention'. This includes that the 'social investment state' prioritises children and risk whilst largely dismissing older people since they are viewed as not being cost effective, as well as representing an unproductive and dependent burden. Indeed policy responses remain 'minimalist' and societal responses 'strangely silent' for older people.

Means et al (2002) highlight the power differences and problems created with regard attempts to distinguish between 'health' and 'social care' needs. For example, they note how social work departments during the 1970s and 1980s felt that they were 'often being 'dumped on' by local NHS services' with regards responsibilities for

social care outside of hospitals in community settings (Glendinning and Means, 2004: 441-442). In relation The King's Fund (2013) articulate another example of professional domination when detailing the common yet negative impact of 'cost shunting' from health to social care within the National Health Service. Beddoe (2013: 35-37) has drawn from Bourdieu (1984) to highlight the multifarious ways by which social work as 'intermediate' profession struggles for legitimacy and influence in contested and competitive fields of praxis such as health care and medicine. She interviewed 40 practitioners involved in 'medical social work' in New Zealand and discovered relatively low professional self-esteem in health centred work arenas such as the hospital and community based multi-professional teams, alongside a regular sense of feeling excluded from clinical debates and decision making. Practitioners were under significant pressures to adhere to biomedical paradigms and practices and resistance to such a dominant discourse often appeared as futile for employees under intense pressures to conform. Additional competition from psychologists and counsellors persisted within the contested discursive fields of social care, and social work practitioners' knowledge bases were identified as lacking the rigour or kudos of medicine. Yet as one social worker highlighted with regards complexity of needs, the social work role tends in practice to demand extensive experience and knowledge:

> It might be being arrogant on my part but I see social workers, more than any other profession needing to have such a vast knowledge of all sort of different things so that you can draw on . . . I think you just, depending which area you go into, it [knowledge] just keeps expanding and your head feels like it will explode sometimes but that is the responsibility we have as social workers.

Nevertheless with regard status, power, legitimacy and influence the social workers interviewed questioned whether they were able to offer alternatives to the dominant paradigms of clinical health or medicine for patients. Moreover, the employees believed that their intense workloads and responsibilities further hindered their motivation and confidence to challenge the powerful narrow, gendered and hierarchal focus placed upon the pathological and behavioural components of health and illness.

Conclusions

Whilst a rapid scramble to promote integrative models of care in England (as elsewhere) has been promoted by the New Labour, Coalition and Conservative Governments since 1997, there remains little research evidence to support the benefits of this powerful policy initiative. Some studies continue to note benefits to multi-agency work for older people (for example, *Help the Aged*, 2007; Andrews et al, 2015) and it is recognised that there are important aspects of social work that invariably rely on good integrative care. Despite this, there has been limited debate regarding the medicalisation of social work and care despite evidence which highlights some of the many deficits of such radical reforms (see for example, Bardsley et al, 2013; Beddoe, 2013; Maddock, 2015). One important consequence of integration has remained a reduction in the total number of qualified social workers involved in the care of older people, an outcome which has been part of a decline in total funding for social care support in England and other parts of the UK. For example, despite the number of people aged 85 and over (the group most likely to need social care) increasing by 30 per cent between 2005 and 2014 in England, only 13 per cent of councils considered people with 'moderate' needs eligible for funding in 2013/14. This figure has declined rapidly from almost half of councils providing similar support in 2005/6. In addition 35 per cent of councils have reduced the number of older people using their services by more than 40 per

cent between 2005/6 and 2012/3; and of 2 million older people assessed to have care related needs, around 800,000 received no formal support. Between 2004 and 2009 net spending on social care for older people increased by a total of 0.1 per cent, while spending on the National Health Service increased by 5 per cent (Phillipson, 2013: 141). This suggests that integration may be as much about reducing cost rather than improving provision. Indeed Estes et al (2003: 86-88) have earlier raised concerns about policies and practices which encompass rationing and cost containment due to 'misplaced notions of productivity' and a sense that, unlike children or younger adults, older people are 'no longer seen as worthy of investment'.

Yet reductions in direct care and financial and professional support are not the only consequences which have followed welfare retrenchment and the promotion of integrated services. Due to complex political and social processes that generate disparities in professional status and power, social work often struggles to maintain an influence in what can be suffocating discursive fields of health and social care praxis. This outcome often links to differences in cultural capital, status, power and the legitimacy or otherwise of conflicting professional knowledge bases. Indeed, as Beddoe (2013: 26) notes, a 'relative lack of independence in health settings suggests that social work has been a 'guest' under the benign control of the medical and nursing professions'. Whilst a flurry of alternative models and theories have emerged to challenge biomedical dominance, some of which carry common support in health care disciplines such as nursing, these tend to have only minor influence or opportunity to be applied within clinical, health and, increasingly, social care settings. Such cross multiagency support for humanistic or critical paradigms may, however, offer a foundation upon which to build sustained collective resistance against the increasing medicalisation of welfare professions and social problems, among other facets of the life course.

Moderate levels of collaboration with health colleagues are clearly also beneficial - and indeed largely inevitable - in many social work roles and casework with older people (for example, around chronic conditions, residential and end of life care), yet full integration is something very different. This carries the risk of blurring the roles and responsibilities of professionals and causing further confusion within fields of practice that already remain deeply fragmented. In relation, the prioritising of numerous social problems facing older people are likely to continue to diminish as priority, or possibly even disappear as concern, in many professional debates and working environments. For example, the corrosive impact of poverty or poor housing, inadequate or unreliable pension provisions or loneliness within an increasingly fragmented and 'atomised' society (see, for example, Bauman and Bordoni, 2014). As Phillipson (2013: 142) suggests, such trends have important ramifications for older people as the retrenchment of welfare and pensions speeds up:

> Conditions in the twenty-first century appear to have resurrected ageing – and late old age especially – as a time of fear and anxiety. Despite the care and support which people receive the 'unknowns' crowd out many of the things to which people might look forward. 'End of life' remains uncertain territory, with the possibility of an incapacitating physical and/or mental condition, and the likelihood of death itself taking place in an unfamiliar space (almost certainly a hospital).

Adult social workers are likely to be most effective when they take a lead in providing advocacy, and delivering meaningful preventative and holistic support for older people and their care givers. Ideally this should be as part of a clearer remit which is at times independent of other professional agendas and discourses.

Note

It is recognised that there are different definitions, interpretations and levels of 'integration' within health and social care. This paper uses the term integration specifically to denote ongoing moves towards a high level of (inequitable) collaboration between social work practitioners and health care professionals or medics and pedagogues. This may include as part of integrated teams, community mental health teams, departments or Faculties working within local authorities, care trusts, hospitals, clinics, Universities or as part of the National Health Service. This may include co-location, shared casework and inter-professional supervision or teaching and research.

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